DOCUMENT RESUME

ED 395 247 CG 027 061

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TITLE Identifying the Presence, Severity, and Chronicity of Psychopathological Behaviors Associated with Adolescent Runaways Using the Personality Inventory for Children.
PUB DATE [93]
NOTE 45p.
PUB TYPE Information Analyses (070) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; *Behavior Disorders; Emotional Problems; *Psychological Characteristics; Psychological Evaluation; Psychological Patterns; *Psychopathology; *Runaways; Secondary Education
IDENTIFIERS *Personality Inventory for Children; University of Tennessee Memphis

ABSTRACT

An extensive review of the adolescent runaway literature indicated inconsistent findings regarding the presence, severity, and chronicity of psychopathological behavior among this high-risk group. Three experiments were conducted to address these issues using one personality measure, the Personality Inventory for Children (PIC). The results of the first experiment indicated that the PIC Typology was able to correctly classify over 93% of the runaway subjects with identified psychopathologies of Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Adjustment Disorder, Major Depression, Dysthymia, Organic Brain Syndrome, Pervasive Developmental Disorder, and Developmental Disorders. No subjects were identified as Within-Normal-Limits. Experiment Two indicated that the runaway group was not significantly different from an outpatient sample or from a Day Treatment Program (partial hospitalization) sample. Both clinical samples evidenced increasing severity of psychopathology. The third experiment indicated that the runaway group was not significantly different from a sample diagnosed Conduct Disorder on 11 scales of the PIC. The results of this study support the utility of the PIC as an initial screening measure only and for identifying the degree of psychological dysfunction that runaways and their families may be experiencing. (Contains 34 references.) (TS)

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ED 395 247

Identifying the presence, severity, and chronicity of psychopathological behaviors associated with adolescent runaways using the Personality Inventory for Children

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Running head: IDENTIFYING PSYCHOPATHOLOGICAL

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Whether behaviors associated with adolescent runaways were indicative of psychopathology has been a much discussed issue in the runaway literature. As early as 1968 the adolescent runaway was viewed as having significant emotional and behavioral problems. The Diagnostic and Statistical Manual of Mental Disorders-II (DSM-II) (American Psychiatric Association, 1968) had the diagnostic category, Runaway Reaction. Discriptors of this diagnosis were running away, timidity, immaturity, feeling rejected by one's parents, having few friends, and having poor problem-solving skills (Jenkins, 1969).

A review by Adams and Munroe (1979) was critical of the literature on the psychopathology associated with adolescent runaways. They concluded that the psychopathological behaviors associated with adolescent runaways could just as well be the consequence of running away rather than being the precipitant of it. The extant research did not support psychological profiles as being adequate predictors of runaway behavior (Adams & Munroe, 1979).

Similarly, a recent review by Burke and Burkhead (1989) concluded that significant psychopathology was not related to runaway behavior. They noted, in fact, that the diagnostic category, Runaway Reaction, had been deleted from the DSM-III (APA, 1980). A failing of the Burke and Burkhead review was that none of the reviewed articles on psychopathology was dated later than 1983.

Presence of Psychopathological Behaviors

The research has indicated that some of the behaviors associated with adolescent runaways may be indicative of the presence of psychopathology. Some noted behaviors were stealing (Edelbrock, 1980), truancy (Nye, 1980), using alcohol and drugs (Maar, 1984), suicidal tendencies (Novy & Donahue, 1985), having been physically abused (Harris, 1980), and sexually abused (Hughes, 1981). The results of the National Network of Runaway and Youth Services (NNRYS) survey (NNRYS, 1985) supported some of the above research findings. The NNRYS surveyed approximately 50,000 youth in 210 runaway facilities and found that some of the primary presenting problems were depression, suicidal tendencies, alcohol and drug

problems, physical abuse, sexual abuse, and the generic category-severe psychological problems. The most recent survey by the NNRYS (1991) essentially replicated their 1985 findings. 50,000 youth in 146 runaway facilities were surveyed. They found that 46% of the youth had a substance abuse problem, with 14% being addicted to a substance. Thirty-one percent reported suffering physical abuse and 21% reported being sexually abused. Sixty-one percent reported being depressed, with 21% having suicidal ideations.

Severity of Problems

While there has been increasing evidence that some of the behavior of adolescent runaways was indicative of the presense of psychopathology, few studies had been conducted to determine the severity of the behavior. Those studies that had been conducted, operationally defined severity by comparing runaways to known clinical groups or indicating that running away was a known variable of an identified clinical group.

One study (Rohr, 1991) used a standardized measure of child and adolescent psychopathology, the Personality Inventory for Children-Revised (PIC-R) (Wirt et al, 1984), and compared a sample of adolescent

runaways to an outpatient sample and a control sample. The outpatient sample had DSM-III diagnostic disorders of depression, anxiety, adjustment reaction, retardation, learning disability, psychosis, and hyperactivity (Lachar, 1990). The control sample had never run away from home nor had they received any mental health services from a professional. The results indicated that the runaway and outpatient samples were significantly different from the control sample on the hypothesized variables of the PIC-R scales Adjustment (ADJ), Achievment(ACH), Depression(D), Family Relations(FAM), Delinquency(DLQ), Social Skills(SSK). The runaway sample was not significantly different from the outpatient sample except on the Delinquency(DLQ) scale. On this scale, the runaway sample had a significantly higher mean score than the outpatient sample, T102 versus T93, respectively.

Another study found that runaways were overrepresented in a group of youth referred for outpatient mental health services (Edelbrock, 1980). There were 682 males aged 12 through 16 and 472 females aged 12 through 16 who had a runaway history. They were compared to a sample of 1300 non-referred youth. Using

the Child Behavior Checklist, Edelbrock (1980) concluded that, based upon the runaway's Child Behavior Profile patterns, they may need comprehensive services, including long-term mental health services. In fact, running away was viewed as a symptom of broader syndromes of psychopathology.

In a third study, Cahill (1988), using the Minnesota Multiphasic Personality Inventory (MMPI), investigated the development of a scale for identifying runaways. One sample consisted of 220 hospitalized adolescents who had a history of running away. Diagnostically, 56% of the inpatient runaways experienced significant physical abuse and neglect, 65% abused alchohol, 68% abused other drugs, and 29% had attempted suicide. Of this group, 17% obtained a 4/8 high point code type which has clinical discriptors of antisocial behaviors in combination with schizophrenic symptomatoloy. Twenty-nine percent obtained a 4/9 code type which includes the classic features of the antisocial personality type. Only 16% of the comparison group, inpatient non-runaways, obtained a high point code type of 4/8 and only 11% obtained a 4/9 code type.

Cahill found that the difference between the inpatient runaways and nonrunaway sample was significant.

Chronicity of Problems

To assess the chronicity of the problems associated with runaways, longitudinal studies had been conducted. Earlier work, such as that of Robins (1958), found that former runaways had higher rates of mental illness, specifically sociopathic personality. Robins and O'Neal (1959) found that former runaways had more frequent arrests and divorces than non-runaways. Later studies indicated that runaways curtailed their schooling, had trouble with the law (Olson, 1977), and required the assistance of social service agencies for nervous and emotional problems (Olson, Liebow, Mannino, & Shore, 1980). In a more recent study (Windle, 1989), a four year follow-up of 14 and 15 year old runaways found that runaway status in early adolescece was associated with subsequent substance abuse, alcohol abuse, and school drop-out status (Windle, 1989).

Methodological problems

An extensive review of research on the presence, severity, and chronicity of the behaviors associated with adolescent runaways revealed some methodological concerns regarding the research on runaways (Rohr, 1991). One problem was the recentcy of the data. Some of the data was relatively old. A more recent sample of adolescent runaways needed to be assessed. Another concern was the validity and reliability of some of the instuments used to assess the presence of diagnostic symptoms thought to be characteristic of runaways. A prior review of those instruments concluded that while the reliability may be somewhat adequate, there was little or no validity data and most of the instuments did not reflect reflect the range of problems/behaviors associated with adolescent runaways. An instument with few psychometric limitations, norms for both genders, and scales that reflect the range of problems of runaways should be used. Another concern was the lack of focus in the research on runaways. The research was inconsistant and not concerted. What seemed lacking was a conceptual orientation to guide and focus the research endeavers. The research should provide

theoretical and empirical direction to understanding the runaway phenomenon. These findings should be of applied and utilitarian value to those professionals working with runaways. A final concern was that the reviews were equivocal in their findings on whether psychopathology was associated with the adolescent runaway. Therefore, the purpose of this study will be to assess a recent sample of adolescent runaways, using one psychometrically sound instrument (PIC) to determine if psychopathology is present, how severe it is, and if it is chronic.

Method

The identification of the presence of psychopathological behavior will be investigated by applying the Personality Inventory for Children (PIC) Profile Typology classification system to the target group. This system yeilds an objective cluster analytically derived interpretation, with corresponding tentative DSM-III diagnoses (Kline, Lachar, & Gdowski, 1987).

Determining the severity of the problems associated with this sample of runaways will be investigated by

comparing the target group to two known clinical groups, an outpatient sample and a Day Treatment Program (partial hospitalization) sample.

The chronicity of the problems associated with this sample of runaways will be investigated by comparing the target group to a clinical group of adolescents with chronic behavior problems: a group whose primary DSM-III or DSM-III-R diagnosis was Conduct Disorder.

Experiment 1

Research Question

Will a sample of adolescent runaways obtain scale scores on the Personality Inventory for Children indicative of psychopathology or will the scale scores be Within-Normal-Limits?

Subjects and data collection

The target group was all of the runaway residents who resided at the Family Link/Runaway House in Memphis, Tennesse between 1986 and 1988, whose custodians/gaurdians (primarily females) completed the PIC prior to their first therapy session. Of the 250 eligable subjects during this period, 63 gaurdians consented to participate. Two subjects' protocols were invalid, reducing the sample size to 61. The age range

was 13 to 17, with a mean age of 15.0. Thirty-five (57.3%) were first time runaways and twenty-six (42.7%) had run away from home more than once.

This naturalistic sample presented with numerous emotional and psychological problems. Assessment findings and clinical interviews conducted by licensed and certified Master's degree level clinicians indicated that 73% met DSM-III or DSM-III-R criteria for either Dysthymia or Major Depression, with 59% having attempted suicide or had suicidal ideations. Nineteen percent had alledged physical abuse. Eighteen percent had alledged sexual abuse. Twenty-nine percent had prior mental health treatment, of which 16% had prior psychiatric hospitalization. These findings were similar to the survey findings of the NNRYS surveys (1985; 1991) as mentioned above.

Additional similarities existed between this sample and national estimates on runaways regarding age, gender, and racial identity. Table 1 illustrates the comparison of the target sample to other samples (Family and Youth Services Bureau (FYSB), 1989; General Accounting Office (GAO), 1989; NNRYS, 1991). Racial

identity and age were the two demographics that were the most similar among the groups. Gender was the most dissimilar.

{ PLACE TABLE 1 ABOUT HERE }

Instrument

The PIC is a 600 item, parent informant, multidimentional measure of child and adolescent behavior, affect, and cognitive ability. The original scales were constructed using either an empirical or rational/content scale construction strategy. The scales were normed on a sample of 2582 normal children (no previous mental health contact; 192 subjects ages 3 to 5; 2390 subjects ages 6 to 16). Norms were established for each gender, ages 3 to 5 and 6 to 16. The standard PIC profile included 3 scales that measured informant response set, Lie (L), Frequency (F), and Defensiveness (DEF); a general screening scale, Adjustment (ADJ); and 3 scales which reflected intellectual and academic functioning, Achievement (ACH), Intellectual Screening (IS), and Development (DVL; and 9 clinical scales, Delinquency (DLQ), Hyperactivity (HPR), Somatic Concern (SOM), Depression (D), Withdrawal (WDL), Anxiety (ANX), severe

psychopathology, Psychosis (PSY), social skills functioning, Social Skills (SSK), and family conflict and parental emotional instability, Family Relations (FAM). Scale scores were reported in T score units (M=50, SD=10); high scores indicated pathological adjustment. Factor-derived broad-band and shortened profile scales were also available (Lachar, 1982; Lachar, Gdowski, & Snyder, 1982).

Lachar's (1982) shortened version of 280 items was used in this study. Estimates of internal consistancy indicated that between the original and shortened forms there was no significant change. Test-retest reliability indicated that the shortened version retained the temporal stability of its full-length counterpart. Correlations between the shortened and full-length versions of the PIC ranged from .88 to .89 (Forbes, 1986). The percentage of clinical interpretive agreement between the original and shortened version scales was from 92% to 97% (Lachar, 1982).

PIC Profile Typology

Gdowski, Lachar, and Kline (1985) used cluster analysis (a statistical algorithm that uses profile data to form groups) and identified a total of 11 PIC

profile types that replicated across two independent samples of almost 900 children and adolescents, each refered for mental health services. These PIC profile types differred significantly across several behavior checklists completed by parents, classroom teachers, and interviewing child clinicians. In addition, the PIC profile groups also differed with regard to child age and sex, but not race or socioeconomic status. Kline, Lachar, and Gdowski (1987) constructed classification rules for this typology to be used with the PIC profiles of individual children/ adolescents. These rules classified over 90% of all cases. Also, a classification rule was developed that identified a twelth PIC profile type: Those profiles that featured a single PIC scale in the clinically elevated range (or "spike" profiles).

The 12 PIC profile types included one group that attained within-normal-limits profiles (WNL; Type 1), described by parents, teachers, and clinicians as exhibiting significantly better adjustment than children who attained other PIC profile types; the afore mentioned "spike" profile group, with only one PIC scale elevation in the clinical range (Type 2);

four profile groups that had significant elevations on PIC scales which measure child cognitive and academic functioning (Type 3,4,5,6), and rated by all informant sources as exhibiting intellectual deficits; and six profile groups (Types 7,8,9,10,11,12) that exhibited various patterns of emotional and/or behavioral problems. This classification system yeilds an average of 40 replicated behavior correlates per profile type, as reported by teacher, parents, and clinicians. Corresponding tentative DSM-III diagnoses were also provided.

Actuarial Interpretation

Additional interpretive strateges were used for those protocols that had just a single scale elevation, TYPE 2 "spike" profiles. Lachar and Gdowski (1979) had developed an actuarial system designed to render interpretive hypotheses or rather assign behavioral correlates to PIC T scores. Differing behavioral correlates were associated with ranges of scores. For instance, with the ADJ scale the same interpretation was given to any scale score 60T and above. Whereas, with the DLQ scale differing interpretations were given

to scale scores between 80-89T, 90-99T, greater than 99T and greater than 109T Procedure

To classify an individual youth's PIC profile, follow down the chart (Figure 1) until the PIC T score satisfies the requirements and the profile is classified as that corresponding Type.

[PLACE FIGURE 1 ABOUT HERE]

Rule 1 identifies all Within-Normal-Limits (WNL) profiles, with scores on all 12 clinical scales in the normal range: (T < 60 for ACH, DVL, FAM, and HPR; T < 70 for IS, SOM, D, WDL, ANX, and SSK; T < 80 for DLQ and PSY). Rule 2 identifies all profiles that have a single, significantly elevated PIC scale and, thus, classifies a total of 12 "spike" types of profiles. The next decision point in the flow chart is whether the T score for IS (Intellectual Screening) is > 69T, which suggests cognitive dysfunction. Rules 3 through 6 classify "cognitive deficit" profile types, which have elevated scores on IS and at least one of the other PIC scales that reflect cognitive functioning (ACH or DVL). Rules 7 through 12 classify "noncognitive deficit" profiles, which have normal-range (T < 70) IS scores, but have elevations on scales that suggest conduct or

emotional problems. An individual youth's PIC profile can be unclassified at two points in this decision tree, and these are indicated by the "Exit" points in Figure 1 (Lachar & Gdowski, 1979a).

Results

Presense of Psychopathology

The PIC classification system was applied to the mean PIC scale profile of the male and female groups (Table 2). The male group was classified TYPE 10. The female group was also classified TYPE 10. The gender groups were then combined. The classification system was applied to the mean PIC scale profile of the total runaway group. The target group, as a whole, was classified TYPE 10.

[PLACE TABLE 2 ABOUT HERE]

The classification system was also applied individually to each of the 61 runaway protocols. Table 3 provides a breakdown of the protocols into the specific PIC Profile TYPES, frequency, and the corresponding DSM-III diagnoses.

[PLACE TABLE 3 ABOUT HERE]

Fifty-seven (93.4%) of the protocols were able to be classified. None of the subjects personality

profiles were a TYPE 1 (Within-Normal-Limits). None of the profiles had only one scale elevated, TYPE 2 ("spike"). Four (6.3%) were not classifiable (EXIT). Twenty-six (42.6%) were a profile TYPE 10. This modal profile indicates that a large proportion of these runaways exhibited behaviors that may meet the criteria for a dignosis of Conduct Disorder-Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder, or Adjustment Disorder with Disturbance of Emotions. The other profile TYPES (3,4,5,7,8,9,11), while indicating that behavioral/conduct problems predominate, also indicate the possible presence of other serious psychological problems. Some runaways may exhibit behaviors that meet the criteria for a diagnosis of Major Depression or Dysthymia, Organic Brain Syndrome, Pervasive Developmental Disorder, or a Developmental Disorder. The PIC psychological profiles were indicative of the presence of psychopathology and the scale scores were not Within-Normal-Limits.

Discussion

By using a standardized measure of adolescent psychopathology, a very different profile of the adolescent runaway emerged. It is one of emotional

disturbance. None of the profiles were Within-Normal-Limits or had only one scale elevated. But, as Adams and Monroe (1979) have reported, was the emotional disturbance a precipitant to running away or a consequence of the episode itself? They further argued that running away was a normal reaction to severe stressors in an adolescent's life, indicating that the youth may have been disturbed prior to running away, in which the running away is symptomatic. Or the running is a coping strategy of a "normal" person in an adverse situation. Brennon, et al (1978) have argued that the experience during the runaway episode itself was traumatic and negative. They found that 23% of runaways reported negative and traumatic experiences such as hunger, cold, fear, rape, being beaten, robbed, and jailed with undesirable adults. This perhaps indicates that the mental health problems were a response to the trauma experienced during the runaway episode. One asset of the PIC is that it is a parent informant test. In the case with this sample of runaways, the parent completed the test prior to the first therapy session with their child. That is, the parent answered questions regarding their childs' behavior which

occured prior to the youth running away, and without knowledge of the events that may have occurred during the runaway episode itself. This studys' findings may lend some creedence to the youth being emotionally disturbed prior to running away. While running away may be a wise, logical response to perceived threat or crisis (abuse, parental psychopathology, neglect, etc.), the conclusions of this experiment indicates, that the adolescent who runs away from home, may have had mental health problems prior to leaving home. How severe those emotional difficulties may have been was the focus of the next experiment.

Experiment 2

Research Question

Will there be a significant difference between an adolescent sample of runaways when compared to an outpatient sample of adolescents and a Day Treatment Program (DTP) sample of adolescents?

Subjects and Data Collection

The runaway group was discribed in the first experiment.

The outpatient comparison group was a random sample of 60 subjects who were from a larger sample of

1226 subjects seen at an outpatient clinic in a midwestern city in 1979 for problematic behavioral and emotional adjustment (Lachar, 1990). Runaway history was not specifically identified in this data set. This was compensated for by eliminating all subjects with a diagnosis of Conduct Disorder, since running away is a criteria for this diagnosis. This was done prior to inclusion in the sample. The age range was 13 through 17 with a mean age of 14.7. Thirty-one (50.8%) were white and 49.2% (30) were black. 50.8% (31) were male and 49.2% (30) were female. Each subject had been given a DSM-III (APA, 1980) diagnostic classification. Categorically, 11 (18.3 %) had a depressive disorder, nine (15.0 %) had an anxiety disorder, 16 (26.7 %) had an adjustment reaction, five (8.3 % were mentally retarded, three (5.0 %) had learning disabilities, six (10.0 %) had a psychotic disorder, and nine (16.7%) were diagnosed with a hyperactivity disorder.

The other comparison group was taken from consecutive admissions, between 1986 through 1991, at a University based Day Treatment Program (partial hospitalization). A random sample of 60 subjects ranged in age from 13 through 17 with a mean age of 14.7.

Forty-one (68.3%) were male and 19 (31.7%) were female. Forty-nine (81.7%) were white and 11 (18.3%) were black. None of these subjects had a history of running away. These subjects had DSM-III (APA, 1980) and DSM-III-R (APA, 1987) diagnostic classifications (primary diagnosis) based upon a complete psychological and/or a psychiatric evaluation and whose case was reviewed by a multidisciplinary team. Specifically, three (5.0%) had a Schizophrenic Disorder, seven (11.6%) had Major Depression, one (1.7%) had Bipolar Disorder, one (1.7%) had Social Phobia, 23 (38.3%) had Dysthymia, four (6.7%) had Separation Anxiety Disorder, three (5.0%) had Post Traumatic Stress Disorder, one (1.7%) had Depressive Disorder-NOS, six (10.0%) had a Conduct Disorder, one (1.7%) had Intermittant Explosive Disorder, two (3.3%) had Overanxious Disorder, three (5.0%) had Oppositional Defiant Disorder, and five (8.3%) had Attention Deficit Hyperactivity Disorder.

Instrument

A discription of the PIC was provided in the first experiment. Previous research indicated that the PIC scales of Adjustment (ADJ), Achievement (ACH), Depression (D), Family Relations (FAM), Delenquency

(DLQ), and Social Skills (SSK) were highly predictive of runaway behavior (Rohr, 1991). The Psychosis scale (PSY) was added in this study as a measure of severity. The PSY scale was constructed to discriminate children with psychotic symptomotology from normal, behaviorally disturbed nonpsychotic, and retarded children (Lachar, 1982).

Results

A ONEWAY ANOVA and post-hoc analysis was performed comparing the target group to an outpatient sample and a Day Treatment Program sample on the PIC variables ADJ, ACH, D, FAM, DLQ, SSK, and PSY. The results indicate that the Runaway sample is not significantly different ($p > .05$) from the Outpatient group. The Runaway group is also not significantly different ($p > .05$) from the Day Treatment Program sample except on one variable, DLQ, $F(3,237)=40.80$, $p < .05$. The critical value of Scheffe's test is 3.98. On this variable, the Runaway sample has a higher mean score than the Day Treatment Program sample, 102T versus 89T, respectively.

Discussion

The delivery of mental health services to adolescents can lie on a continuum of least to most restriction. That is, outpatient services are provided in a least restictive enviornment while inpatient services are provided in a most restictive setting. The Day Treatment Program (partial hospitalization) services is middle alternative to these extremes (Pruit and Kiser, 1991). Accessing mental health services depends, in part, upon the severity of the mental health problem. By comparing the runaway sample, whose behavioral characteristics are indicative of the presence of psychopathology, to two clinical groups with known mental health problems that vary in severity, an estimate of the severity of the problems of runaways can be made. The results indicate that the PIC psychological profiles of the adolescent runaway is not significantly different than the psychological profile of an adolescent Outpatient or Day Treatment Program sample. The possibility exists that runaways may be even more emotionally/behaviorally impaired than the DTP sample as measured by the DLQ scale alone.

A finding of Experiment 1 was that the modal diagnosis for the runaway group was Conduct Disorder. Antisocial child behavior includes aggressive acts, vandalism, lying, theft, firesetting, running away, and acts that reflect major social rule violations (Kazdin, 1992). A persistant pattern of such behaviors is referred to as Conduct Disorder. A diagnosis of Conduct Disorder during adolescence portends continued dysfunction in adulthood (Rutter and Giller, 1983). If the behavior of adolescent runaways is of a chronic type, one way of determining the chronicity is to compare them to a group with a known chronic behavioral problem, Conduct Disorder. This will be the focus of experiment 3.

Experiment 3

Research Question

Will there be a significant difference, on the PIC variables ADJ through SSK, between a sample of adolescent runaways and a sample of adolescents diagnosed Conduct Disorder?

Subjects and data collection

The Runaway sample was described in Experiment 1.

The comparison group consisted of adolescents from outpatient and a Day Treatment Program settings who had a primary DSM-III or DSM-III-R diagnosis of Conduct Disorder. The total number of subjects was 20. They ranged in age from 13 to 17 with a mean age of 14.8. Sixteen (80%) were male and four (20%) were female. Twelve (60%) were white and eight (40%) were black.

Instrument

The PIC was described in Experiment 1.

Results

A ONEWAY ANOVA was carried out comparing the target group to the Conduct Disordered group on the PIC variables ADJ through SSK. The results indicate that the target group is not significantly different ($p > .05$) from the Conduct Disordered group on any of the 13 clinical scales of the PIC-R, ADJ through SSK.

Discussion

The determination of the chronicity of the problems runaways experience was done in a manner similar to that determining the severity of the runaways problems. The results indicate that the psychological profiles (behaviors and symptoms) of adolescent runaways were quite similar to the

psychological profiles of adolescents with a known clinical diagnosis of Conduct Disorder. This lack of significant difference stongly suggests that the psychopathological behaviors that runaways exhibit, if untreated, may persist into adulthood and they will be of a chronic and dysfunctional type. According to Rutter and Giller (1983) conduct disordered adolescents, as adults, are far more likely to show persisting psychiatric and social impairment.

General Disscussion

The PIC Profile classification system is an empirically derived typology of child and adolescent psychopathology. The application of the typology to the runaway group resulted in over 93% of the protocols being classified. The tentative diagnoses associated with the modal classification Type 10, were Conduct Disorder, Attention Deficit with Hyperactivity Disorder, and Adjustment Disorder. The possible diagnosis of Conduct Disorder substantiates therapists' intuitive and clinical experience with runaways and the problems they present. Attention must also be given to other possible diagnoses associated with the target group. They include Organic Brain Syndrome, Pervasive

Developmental Disorder, Depression (Major, Dysthymia) and Developmental Disorders. There were no protocols that were a Type 1, WITHIN NORMAL LIMITS. Also, no protocols had only one scale elevated, Type 2 or SPIKE.

The comparison of the runaway group to two known clinical groups indicated that the severity of the problems runaways experience fell along a continuum. Pruit and Kiser (1991) presented a continuum of care model of mental health services for children and adolescents. They stated that the mental health services were prevention, outpatient, partial care (Day Treatment Progam), inpatient, and residential treatment centers. It can be argued that the degree of severity typically associated with those five systems of care are mild, mild-moderate, moderate-severe, severe, and chronic long term, respectively. Given this association and that the runaway group was not significantly different from the outpatient and Day Treatment Program groups, the severity of the problems that runaways experience may range from mild to moderately severe and perhaps even severe. Severe is mentioned because the runaway group had a significantly

higher mean score on the Delinquency (DLQ) scale than did the Day Treatment Program group.

Runaway Program staff are continually challenged by a persistent increase of serious mental health problems presented by their clients. Some pertinent findings of the NNRYS (1985) survey were that runaway programs were seeing youth, who presented with problems that were more psychologically serious than those youth of 5 to 6 years earlier. They noted a need for more professionally trained staff. This survey also voiced a need for more comprehensive mental health services to meet the needs and problems of these severely troubled youth and their families. Those problems were parental drug use, victimization issues, youth alcohol and drug use, suicide, and serious psychiatric problems (NNRYS, 1985).

This study demonstrates that the psychological profile associated with the adolescent runaway is symptomatic of psychopathology. The degree of psychopathology may range from mild (outpatient) to moderately severe (Day Treatment Program), with a constellation of problems (Conduct Disorder) that can be quite resistant to therapeutic intervention and can

be eventually severely debilitating. While Chwast, (1977) advocated that therapy with adolescent runaways be conducted on the premises of the runaway program, the severity of the problems that runaways present with may require services that the runaway program cannot feasibly provide. What a runaway program can provide, in addition to their current services, is competant psychological assessment of psychopathology and a triage protocol in order to access the mental health services needed for intervention with the adolescent and their family on a systemic level.

This study has several limitations that may restrict generalization of the findings. Stratified random samples were not always collected for this study. Time restictions prohibited further collection of data. The time invested in collecting the data was already two years. Runaway programs are crisis facilities and the nature of such programs sometimes may prohibit parents completing assessment instruments, despite their value and utility (Rohr, 1991). Additionally, the behaviors associated with runaways may meet the criteria for numerous psychopathologies. But, the PIC is not a substitute for a complete

psychological evaluation. The results of this study support the utility of the PIC as an initial screening measure only and for identifying the degree of psychological dysfunction that runaways and their families may be experiencing.

Recomendations

The use of the PIC, as part of an assessment process, in Runaway Programs or other mental health settings (community mental health centers, schools) that work with runaways, is stongly encouraged. The clinical information generated by the PIC and it's interpretive methods about the youth, parents, and families would greatly aid in treatment planning and the type of referral needed for follow-up services. In addition, the professional, legal, and ethical restrictions on using personality tests necessitates runaway programs having qualified staff to administer and interpret the instument. The use of qualified mental health professionals in runaway programs would address the reccomendations by the NNRYS survey (1985).

References

American Psychiatric Association (1968). Diagnostic and statistical manual of mental disorders (2nd ed.). Washington, DC: Author.

American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

Adams, G. R., & Munro, G. (1979). Portrait of the North American runaway: a critical review. Journal of Youth and Adolescence, 8(3), 359 - 373.

Brennan, T., Huizings, D., & Elliot, D. S. (1978). The social psychology of runaways. Lexington, MA: D.C. Heath.

Burke, W. H. & Burkhead, E. J. (1989). Runaway children in America: a review of the literature. Education and Treatment of Children, 12, 1, 73 - 81.

Cahill, K. R. (1988). The prediction of adolescent runaway: psychometric and demographic approches. Doctoral dissertation, University of Nebraska, Lincoln, 1988). Dissertation Abstacts International, 50, 3, 1149B.

Chwast, R. (1977). Psychotherapy of disadvantaged acting-out adolescents. American Journal of Psychotherapy, 31, 216-226.

Edelbrock, C. (1980). Running away from home: incidence and correlates among children and youth referred for mental health services. Journal of Family Issues, 1(2), 210 - 228.

Family and Youth Services Bureau. (1990). Annual report to the Congress on the Runaway and Homeless Youth Program fiscal year 1989. Washington, DC.

Forbes, G. B. (1986). Comparison of the short and original scales of the Personality Inventory for Children. Journal of Clinical Psychology, 42, 129-132.

Gdowski, C. L., Lachar, D., and Kline, R. B. (1985). A PIC profile typology of children and adolescents: I. empirically derived alternative to traditional diagnosis. Journal of Abnormal Psychology, 94, 3, 346-361.

Harris, L. (1980). Middle-class high school dropouts: incidence of physical abuse, incest, sexual assault, symtomatic behavior, and emotional disturbance (Doctoral dissertation, University of Minnesota, 1980). Dissertation Abstracts International, 41, 2058A.

Hughes, K. A. (1981). The reported incidence of incest among runaway female adolescents (Doctoral dissertation, California School of Professional Psychology, Berkeley, 1980). Dissertation Abstracts International, 41, 4638B.

Jenkins, R. (1969). Classification of behavior problems in children. American Journal of Psychiatry, 125(8), 1032-1039.

Kazdin, A. E. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. Journal of Consulting and Clinical Psychology, 60, 5, 733-747.

Kline, R. B., Lachar, D. & Gdowski, C. L. (1987). A Personality Inventory for Children profile typology of children and adolescents: II. classification rules and specific behavior correlates. Journal of Clinical Child Psychology, 16, 3, 225-234.

Lachar, D. and Gdowski, C. L. (1979). Actuarial Assessment of Child and Adolescent Personity: an interpretive guide for the Personality Inventory for Children profile. Los Angeles: Western Psychological Services.

Lachar, D. (1982). Personality Inventory for Children (PIC): Revised Format Manual Supplement. Los Angeles: Western Psychological Services.

Lachar, D., Gdowski, C. L., & Snyder, D. K. (1982) Broad-band dimensions of psychopathology: Factor scales for the Personality Inventory for Children. Journal of Consulting and Clinical Psychology, 50, 634-642.

Lachar, D. (1990). [Adolescent outpatient data set of PIC-R profiles]. Unpublished data.

Maar, J. E. (1984). Critical factors related to adolescent runaway behavior in the state of Florida (Doctoral dissertation, The Florida State University, 1984). Dissertation Abstracts International, 45, 2993A.

National Network of Runaway and Youth Services, Inc. (1985). A profile of America's runaway and homeless youth and the programs that help them. Washington, DC: Author.

National Network of Runaway and Youth Services, Inc. (1991). To whom do they belong. Washington, DC: Author.

Novy, D. M. & Donohue, S. (1985). The relationshiccp between adolescent life stress events and delinquent conduct including conduct indicating a need for supervision. Adolescence, 20, 313-321.

Nye, F. I. Runaways: Some critical issues for professionals in society. Cooperative Extension Bulletin - 0744, Washington State University, 1980.

Olson, L. R. (1977). Suburban runaways: a follow up study (Doctoral dissertation, University of Maryland, 1977). Dissertation Abstracts International, 38, 2379B.

Olson, L., Liebow, E., Mannino, F. V., & Shore, M. F. (1980). Runaway children twelve years later: a follow up. Journal of Family Issues, 1(2), 165-188.

Pruitt, D. B. & Kiser, L. J. (1991). Day Treatment: Past, Present and Future. In Child and Adolescent Psychiatry: A Comprehensive Textbook. (Ed. M. Lewis). Baltimore: Williams and Wilkins.

Robins, L. N. (1958). Mental illness of the runaway: A 30-year follow-up study. Human Organization, 16, 1-15.

Robins, L. N., & O'Neal, P. (1959). The adult prognosis for runaway children. American Journal of Orthopsychiatry, 29, 752-761.

Rohr, M. E. (1991). Personality profile of adolescent runaways. (Doctoral dissertation, Memphis State University, 1991). Dissertation Abstacts International, 52, 4, 1215A.

Rutter, M. and Giller, H. (1983). Juvenile Delinquency: Trends and Perspectives. New York, The Guilford Press.

Windle, M. (1989). Substance use and abuse among adolescent runaways: a four-year follow-up study Journal of Youth and Adolescence, 18, 4, 331-344.

Wirt, R.D., Lachar, D., Klinedinst, J.K., & Seat, P.D. (1984). Multidimensional Description of Child Personality: A manual for the Personality Inventory for Children. Los Angeles: Western Psychological Services.

TABLE 1

Comparison of runaway sample and national estimates on runaway demographics (age, sex, race).

Group	Runaway	GAO	FYSB	NNRYS
Age <14	36.1%	NA	42%	38%
Age 15-17	63.9%	NA	56%	54%
Male	18%	35%	43%	47%
Female	82%	65%	57%	53%
Black	36.1%	NA	NA	20%
White	63.9%	NA	NA	75%

TABLE 2

PIC mean scale T scores for runaway males, females and total runaway group

SEX	SCALE												
	ADJ	ACH	IS	DVL	SOM	D	FAM	DLQ	WDL	AN	PSY	HPR	SSK
MALE	98	66	69	64	60	77	58	106	65	67	73	74	67
FEM	86	58	49	57	58	71	63	101	63	63	70	65	63
TOTAL	89	60	53	58	59	72	62	102	63	64	71	67	64

TABLE 3

PIC profile type classification of adolescent runaways

Profile	Freq	%	DSM-3 diagnosis
1	0	0.0	(WNL)
2	0	0.0	(SPIKE)
3	3	4.9	Organic Brain Syndrome, Pervasive Developmental Disorder, Mixed Specific Developmental Disorder, Adjustment Disorder with Disturbance of Conduct
4	8	13.1	Conduct Disorder - Undersocialized Aggressive, Specific Developmental Disorder, Attention Deficit Hyperactivity Disorder
5	0	0.0	Mental Retardation, Pervasive Developmental Disorder, Adjustment Disorder with Disturbance of Conduct

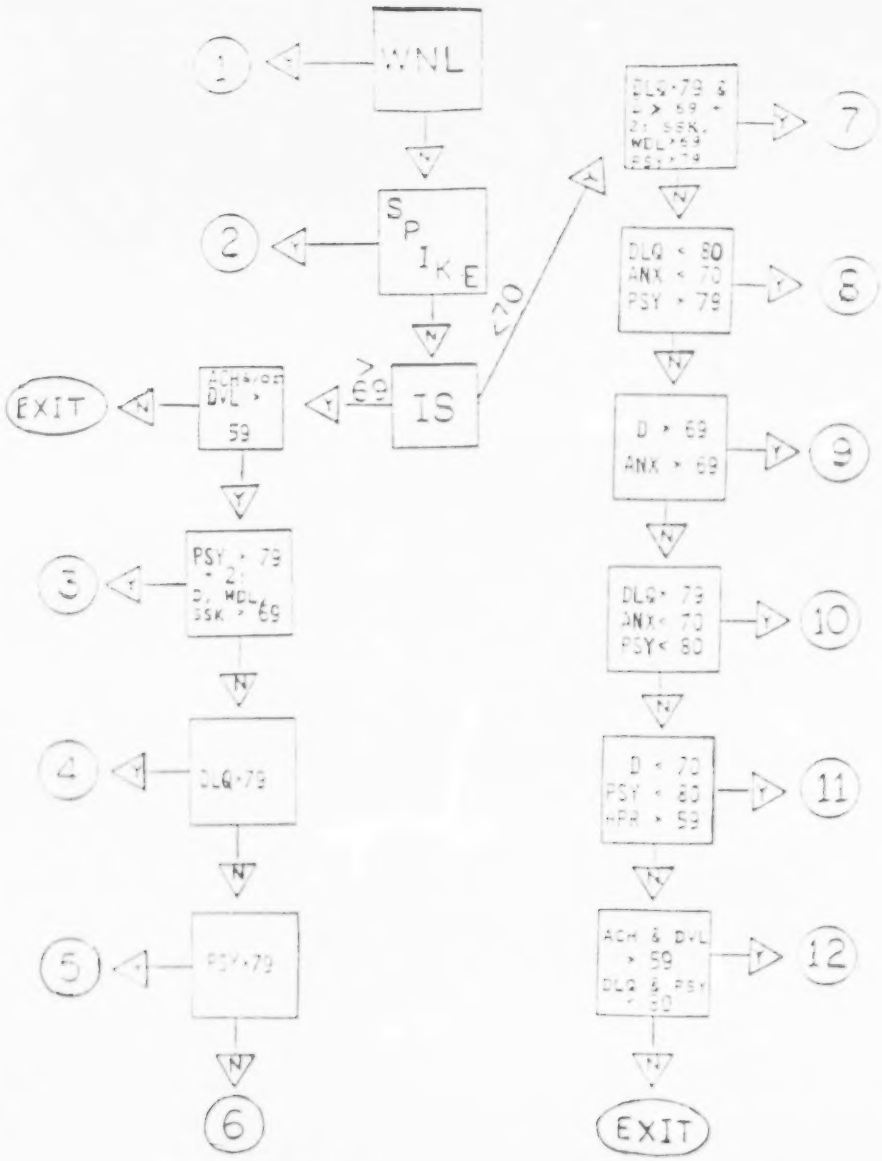
6	0	0.0	Specific Developmental Disorder, Adjustment Disorder with Disturbance of Conduct
7	8	13.1	Conduct Disorder - Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder, Major Depression
8	3	4.9	Attention Deficit Hyperactivity Disorder, Pervasive Developmental Disorder, Developmental Language Disorder
9	5	8.1	Dysthymia
10	26	42.6	Conduct Disorder - Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder, Adjustment Disorder with Disturbance of Emotions
11	4	6.5	Attention Deficit Hyperactivity Disorder, Adjustment Disorder with Disturbance of Conduct

12	0	0.(	Specific Developmental Disorder, Adjustment Disorder with Mixed Disturbances of Emotion and Conduct, Attention Deficit Disorder with/without Hyperactivity
EXIT	4	6.9	

Total: 61 100%

Classification Rate: 93.4%

FIGURE 1


WNL
SPIKE
IS
≥ 69
< 70
EXIT
ACH & DVL > 59
PSY > 79 & 2; D, MOL, SSK > 69
DLQ > 79
PSY > 79
DLQ > 79 & < > 69 < 2; SSK, MOL > 69 ES > 79
DLQ < 80 ANX < 70 PSY > 79
D > 69 ANX > 69
DLQ > 79 ANX < 70 PSY < 80
D < 70 PSY < 80 HPR > 59
ACH & DVL > 59 DLQ & PSY > 80
EXIT
1
2
3
4
5
6
7
8
9
10
11
12